IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 01-1862 EMSL

DR. CHARLES THOMAS SELL, D.D.S.
Appellant,

v.

THE UNITED STATES OF AMERICA
Appellee.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MISSOURI

Case No. 4:97CR290-DJS
Case No. 4:98CR177-DJS
The Honorable Judge Donald J. Stohr

BRIEF OF APPELLANT

FEDERAL PUBLIC DEFENDER
Norman S. London
First Assistant Federal Defender
Lee T. Lawless
1010 Market Street, Suite 200
St. Louis, Missouri 63101
(314) 241-1255
(314) 421-3177

LEWIS, RICE & FINGERSH, L.C.
Barry A. Short
500 N. Broadway, Suite 2000
St. Louis, MO 63102
(314) 444-7600
(314) 241-6056

Appointed Attorneys for Appellant
Dr. Charles Thomas Sell

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St. Louis, MO 63102
(314) 444-7600
(314) 241-6056

Appointed Attorneys for Appellant
Dr. Charles Thomas Sell

SUMMARY OF THE CASE AND REQUEST FOR ORAL ARGUMENT

Dr. Charles Thomas Sell ("Dr. Sell") is an unconvicted detainee confined in the United States Medical Center for Federal Prisoners (the "Center") in Springfield, Missouri. Psychiatrists and psychologists have diagnosed Dr. Sell as suffering from delusional disorder, persecutory type. On April 14, 1999, the District Court found Dr. Sell incompetent to stand trial. Pursuant to 18 U.S.C. § 4241(c), the District Court committed Dr. Sell to the custody of the United States Attorney General, who in turn committed Dr. Sell to the Center to determine whether Dr. Sell could be restored to competency.

On August 9, 2000, a United States Magistrate Judge authorized the Center to forcibly administer antipsychotic drugs to Dr. Sell (the "August 9, 2000 Order") based upon a finding of dangerousness. On April 4, 2001, the District Court reversed the Magistrate Judge's finding of dangerousness, but affirmed the order on the alternative ground that involuntary medication was appropriate for the sole purpose of restoring Dr. Sell to competency to stand trial.

Dr. Sell requests oral argument for thirty minutes in this case because of the serious constitutional, moral and medical issues implicated by the involuntary medication issue and because oral argument would assist the Court in conducting the complex involuntary medication analysis.

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JURISDICTIONAL STATEMENT

Dr. Charles Thomas Sell, D.D.S. appeals from an April 4, 2001 Order entered by the District Court for the Eastern District of Missouri (the "District Court"). In that Order, the District Court authorized the United States Government to forcibly drug Dr. Sell with antipsychotic medication for the sole purpose of restoring Dr. Sell's competency to stand trial. Dr. Sell timely filed his Notice of Appeal on April 13, 2001.

This Court has jurisdiction over Dr. Sell's appeal pursuant to 28 U.S.C. § 1291 and the "collateral order doctrine." *See United States v. Morgan*, 193 F.3d 252, 259 (4th Cir. 1999) (holding that an involuntary medication order was immediately appealable). Under the collateral order doctrine, a party may take an interlocutory appeal from non-final orders which "finally determine claims of right separable from, and collateral to, rights asserted in the action, too important to be denied review and too independent of the cause itself to require that appellate consideration be deferred until the whole case is adjudicated." *United States v. Davis*, 93 F.3d 1286, 1289 (6th Cir. 1996) (quoting *Cohen v. Beneficial Indus. Loan Corp.*, 337 U.S. 541, 69 S. Ct. 1221, 93 L.Ed. 1528 (1949)).

To fall within the collateral order doctrine, the order must (1) conclusively determine the disputed question, (2) resolve an important issue completely separate from the merits of the action, and (3) be effectively unreviewable on appeal from a

final judgment. *Davis*, 93 F.3d at 1289. In this case, as in *Morgan*, the requirements of the collateral order doctrine are satisfied. First, the April 4, 2001 Order conclusively determines that the government is entitled to forcibly medicate Dr. Sell. Second, the issue of involuntary medication is completely independent from the issue of Dr. Sell's guilt or innocence. Third, forcible medication will be effectively unreviewable on appeal from the final judgment. Therefore, this Court has jurisdiction over Dr. Sell's appeal from the District Court's April 4, 2001 Order. *See also, e.g.*, *United States v. Brandon*, 158 F.3d 947, 951 (6th Cir. 1998) (holding that district court decision as to the procedural safeguards required for the involuntary medication inquiry was an appealable order under the collateral order doctrine).

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

I. WHETHER A DEFENDANT MAY BE FORCIBLY INJECTED WITH ANTIPSYCHOTIC DRUGS FOR THE SOLE PURPOSE OF RESTORING THE DEFENDANT'S COMPETENCY TO STAND TRIAL, WHERE THE ONLY SHOWING OF EXTRAORDINARY CIRCUMSTANCES IS THE NATURE OF THE CRIMINAL CHARGES?

Woodland v. Angus, 820 F. Supp. 1497, 1504 (1993)

Washington v. Harper, 494 U.S. 210, 110 S.Ct. 1028 (1990)

Riggins v. Nevada, 504 U.S. 127 (1992)

United States v. Weston, 134 F. Supp. 2d 115, 2001 WL 286406, No. CRIM. A. 98-357 (D.D.C. March 6, 2001)

II. WHETHER THE DISTRICT COURT IMPROPERLY RELIEVED THE GOVERNMENT OF PROVING EACH OF THE INVOLUNTARY MEDICATION ISSUES BY CLEAR AND CONVINCING EVIDENCE?

United States v. Weston, 134 F. Supp. 2d 115, 2001 WL 286406, No. CRIM. A. 98-357 (D.D.C. March 6, 2001)

Riggins v. Nevada, 504 U.S. 127 (1992)

Woodland v. Angus, 820 F. Supp. 1497 (1993)

United States v. Brandon, 158 F.3d 947 (6th Cir. 1998)

III. WHETHER THE DISTRICT COURT IMPROPERLY ADOPTED THE MAGISTRATE JUDGE'S DEFERENTIAL FINDINGS OF FACT WITH REGARD TO THE LIKELIHOOD OF RESTORING DR. SELL'S COMPETENCY AND THE MEDICAL APPROPRIATENESS OF FORCIBLE MEDICATION WHEN THE DISTRICT COURT'S RULING REQUIRED APPLICATION OF THE MORE STRINGENT STRICT SCRUTINY STANDARD?

Youngberg v. Romeo, 457 U.S. 307, 102 S. Ct. 2452 (1982)

United States v. Brandon, 158 F.3d 947, 957 (6th Cir. 1998)

United States v. Morgan, 193 F.3d 252 (4th Cir. 1999)

Washington v. Harper, 494 U.S. 210, 110 S.Ct. 1028 (1990)

IV. WHETHER THE DISTRICT COURT ERRED BY FAILING TO CONDUCT A PRE-MEDICATION SIXTH AMENDMENT INQUIRY?

U.S. CONST. amend. VI

Riggins v. Nevada, 504 U.S. 127 (1992)

United States v. Brandon, 158 F.3d 947, 957 (6th Cir. 1998)

United States v. Weston, 206 F.3d 9, 14 (D.C. Cir. 2000) (emphasis added)

STATEMENT OF THE CASE

Dr. Sell is an unconvicted detainee confined in the United States Medical Center for Federal Prisoners (the "Center") in Springfield, Missouri. Psychiatrists and psychologists have diagnosed Dr. Sell as suffering from delusional disorder, persecutory type. On April 14, 1999, the District Court found that Dr. Sell was incompetent to stand trial. (ROA at 341-43). Pursuant to 18 U.S.C. § 4241(c), the District Court committed Dr. Sell to the custody of the United States Attorney General, who in turn committed Dr. Sell to the Center for a reasonable period of time to determine whether Dr. Sell could be restored to competency. Dr. Sell has now been confined in the Center for over two years.

On August 9, 2000, the United States Magistrate Judge authorized the Center to forcibly administer antipsychotic drugs to Dr. Sell (the "August 9, 2000 Order") based upon a finding that Dr. Sell posed a danger to himself and others. (ROA at 805-821). The Magistrate Judge denied Dr. Sell's Motion for Reconsideration. (ROA at 843-45).

Dr. Sell then sought review of the Magistrate Judge's decision with the District Court. On April 4, 2001, the District Court entered an order reversing the Magistrate Judge's finding of dangerousness, but affirming the August 9, 2000 Order on an alternative ground. The District Court held that involuntary medication was

appropriate for the sole purpose of restoring Dr. Sell to competency to stand trial. Dr. Sell appeals from this April 4, 2001 Order.

STATEMENT OF FACTS

I. Dr. Charles Thomas Sell

Dr. Charles Thomas Sell ("Dr. Sell") is a fifty-one year old dentist who is currently confined in the United States Medical Center for Federal Prisoners (the "Center") in Springfield, Missouri. (Record on Appeal ("ROA") at 1108, 1136). He graduated from St. Louis University with a major in biology/chemistry in 1972 and graduated with a doctorate in dental surgery from the University of Missouri-Kansas City in 1976. (ROA at 1099, 1108, 1137). While in school, Dr. Sell worked for the Humane Society of Missouri, taught biology at St. Louis University, and worked for City Hospital in Kansas City as a lab technician. (ROA at 1120, 1121). After graduation, he obtained his dental license from the Missouri Dental Board (ROA at 1136) and opened a private dental practice in Des Peres, Missouri. (ROA at 1108). In private practice, he performed general dentistry, endodontica, oral surgery, periodontics, pedodontics, prosthodontics and geriatric dentistry. (ROA at 1099). His practice thrived in this relatively affluent area of St. Louis County.

In 1977, Dr. Sell married his first wife, Deborah. (ROA at 1091). They shared a home in Kirkwood, Missouri, and had three children together: Charles James, Matthew Thomas and Rebecca Lynn. (ROA at 1087, 1091, 1114). In

1983, Barbara left him, an event that caused him extreme emotional difficulty. (1999 Forensic Pathology Report ("1999 FPR") at 3).

In 1982, Dr. Sell had joined the United States Army Dental Reserve. (ROA at 1130, 1106-1108); (1999 FPR at 3). He received officer training at Fort Sam Houston in Texas. After training, the army promoted him to the rank of captain. (ROA at 1094); (1999 FPR at 3). He excelled at his assigned tasks, and effective January 11, 1990, the army promoted him to the rank of major. (ROA at 1085). In the army, he completed a number of courses with distinction, including a Command and General Staff Officer Course (ROA at 1079, 1081, 1084), an Amedd Officer Basic (Reserve Component) Course (ROA at 1089), Basic Medical Terminology (ROA at 1198), Nuclear Weapons Fundamentals (ROA at 1200), Psychological Operations (ROA at 1201), Introduction to C & R Opn and Biology Definitions (ROA at 1199), and Battalion Training Management System (ROA at 1210). He also received awards for his exemplary service, including the U.S. Army Reserve Components Achievement Medal (ROA at 1080, 1138, 1139) ("Reports from his prior supervisors indicate that his service to this dental activity during his active duty for training was very good. He provided caring and competent patient treatment during his active duty period. He has been a definite asset to this dental activity . . . ."). The army's assessments of Dr. Sell's military performance were uniformly outstanding. (ROA at 1142-1159; 1161-1174; 1177)

("MAJ Sell excelled in his ability to deliver high quality dental care while performing his duties . . . on annual training . . . . He was well received by his patients and constantly volunteered for extra work. MAJ Sell's easygoing manner and excellent attitude helped to contribute to the esprit-de-corps of the clinic . . . .").

In 1984, Dr. Sell fell in love with his then dental assistant and later wife, Mary, and the couple conceived Dr. Sell's fourth child, Robert L. Sell, in 1987. (ROA at 1087).

During the 1980s and continuing into the 1990s, Dr. Sell occasionally suffered from recurrences of the emotional difficulties that had surfaced during his divorce from Deborah (*See, e.g.,* 1997 Forensic Report ("1997 FR") at 3), and he periodically sought the assistance of psychiatrists or psychologists (*Id.*). He received psychotherapy, and, at times, his clinician treated him with antidepressants. (*See, e.g.*, 1997 FR at 5). Once, in the early 1980s, he was briefly treated with an antipsychotic drug, Haldol. (ROA at 589); (1999 FPR, pg. 3). Dr. Sell found the side effects of the drug to be intolerable. (ROA at 617) (Dr. Wolfson testifying that Dr. Sell had suffered, at minimum, dystonic reaction from Haldol and that Dr. Sell had complained that Haldol gave him "all types of problems"). In fact, Dr. Sell has likened taking antipsychotic drugs to a lobotomy. He has been opposed to antipsychotic medication ever since.

II. Criminal Proceedings.

On May 16, 1997, the Government filed a complaint alleging that Dr. Sell had committed insurance fraud by, among other things, submitting doctored invoices to insurers for the purpose of obtaining payment for services that were not covered by the policies. (*See, e.g.*, 1997 FR at 1).

On May 20, 1997, the United States Government moved for a psychiatric examination to assess Dr. Sell's competency to stand trial. (ROA at 3-5). A Magistrate Judge ordered Dr. Sell transferred to the Center for a psychological assessment (ROA at 8-10) and ordered that a competency hearing be held on July 5, 1997 (ROA at 11-12). The Center conducted a psychological assessment and on June 20, 1997 provided the Magistrate Judge with a Forensic Report setting forth the Center's findings. (1997 FR). The conclusions in the Forensic Report were tentative because Dr. Sell refused to discuss his case history with the evaluator. (1997 FR at 2). The neuropsychologist who assessed him provided the following assessment to the court:

> It must be noted that the undersigned evaluator provides this opinion with less confidence than customary . . . . [I]t is the undersigned evaluator's opinion that Charles Thomas Sell does not currently suffer from a mental disease or defect, and that he is competent to the extent he is able to understand the nature and consequences of the proceedings against him and assist properly in his defense.

PROGNOSIS

> Currently, Dr. Sell evidences no obvious signs of psychosis. It is likely his mental status should stay consistent in the near future, but there is a possibility he could develop a psychotic episode depending on the nature of any past mental illness. It is impossible for the undersigned evaluator to be more specific given the lack of information. He does have a [sic] paranoid personality characteristics which are pervasive and will color interactions between Dr. Sell, counsel, and the Court.

(1997 FR at 8).

After the July 5, 1997 hearing, in which the court considered the Forensic Report, the court held by a preponderance of the evidence that Dr. Sell was competent to stand trial. (ROA at 14-17).

On July 30, 1997, Dr. Sell was indicted for Medicaid and insurance fraud (#4:97CR00290DJS).

On August 27, 1997, Dr. Sell was released on bond. However, on January 26, 1998, his bond was revoked and Dr. Sell was again arrested. This time, the Government charged Dr. Sell with conspiracy to prevent witness attendance, conspiracy to commit murder, and attempted murder, charges which culminated in an April 23, 1998 indictment (#4:98CR177CEJ). The Government's charges were based upon allegations that Dr. Sell had engaged in the incipient stages of soliciting a hitman to kill a government witness against him. Specifically, the Government had taped a conversation between Dr. Sell and a

Government informant that the Government believed evidenced a plot to kill an F.B.I. agent.

On October 14, 1998, counsel for Dr. Sell filed their notice of intent to introduce evidence of mental disease or defect (ROA at 285-86), and, in response, the Government requested an additional psychiatric examination (ROA at 287-88, 303-07), which Dr. Sell opposed (ROA at 293-302). On November 25, 1998, the Magistrate Judge denied the Government's request for a second competency determination, but ordered a second psychological assessment based upon Dr. Sell's interposition of the diminished capacity defense (ROA at 308-17).

Counsel for Dr. Sell then enlisted the services of a private psychologist, Dr. C. Robert Cloninger, to conduct an independent assessment of Dr. Sell's competency. (ROA at 326-327). Dr. Cloninger is a Wallace Renard Professor of Psychiatry at Washington University, a Professor of Genetics & Psychology at Washington University, and the Director of the Center for Psychobiology of Personality with an extensive educational background in the psychology of delusional disorder and personal experience in treating patients with the disorder. (ROA at 417-458) (Dr. Cloninger's curriculum vitae). He has over two hundred publications to his credit. (*Id.*) He was head of the Department of Psychiatry at Washington University from 1989 to 1994. (ROA at 419).

Dr. Cloninger examined Dr. Sell, who cooperated in the examination. Dr. Cloninger reviewed Dr. Sell's medical records, and spoke personally with Dr. Sell's prior treating physicians. Dr. Cloninger concluded that Dr. Sell suffered from Delusional Disorder, Persecutory Type, and advised Dr. Sell's counsel that Dr. Sell was not competent to stand trial. (ROA at 326-27). Counsel for Dr. Sell moved for a second competency hearing. (ROA at 326-327). On February 16, 1999, the Government moved for a competency assessment pursuant to 18 U.S.C. § 4241(b) (ROA at 330-332), which the Magistrate Judge granted on February 22, 1999 (ROA at 337-339). The Center again assessed Dr. Sell and provided the court with a second Forensic Psychology Report (the "1999 FPR"). In the 1999 FPR, the Center agreed with Dr. Cloninger's diagnosis and found that Dr. Sell's persecutory delusions were specifically directed to the United States Government and its agents. (*See* 1999 FPR at 8). The Center further found that Dr. Sell was not greatly impaired, was not schizophrenic, did not suffer from bizarre delusions, and did not display prominent hallucinations. (*Id.*).

Based upon these findings, the District Court found Dr. Sell incompetent to stand trial on April 14, 1999 because Dr. Sell "suffer[ed] from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him and to assist properly in his defense." (ROA at 341-43). Pursuant to 18 U.S.C. §4241(c),

the court committed Dr. Sell to the custody of the United States Attorney General for a reasonable period of time "not to exceed four months." The Department of Justice then committed Dr. Sell to the custody of the Center, where he has been confined now for over two years.

III. Delusional Disorder

Both Dr. Cloninger and Center staff have diagnosed Dr. Sell as suffering from delusional disorder, persecutory type. *See, e.g.*, (ROA at 632); (1999 FPR at 8). The *Diagnostic and Statistical Manual of Mental Disorders* IV ("DSM-IV") describes the diagnostic features of delusional disorders as follows:

> The essential feature of Delusional Disorder is the presence of one or more nonbizzare delusions that persist for at least 1 month (Criterion A). A diagnosis of Delusional Disorder is not given if the individual has ever had a symptom presentation that met Criterion A for Schizophrenia (Criterion B). Auditory or visual hallucinations, if present, are not prominent. Tactile or olfactory hallucinations may be present (and prominent) if they are related to the delusional theme (e.g., the sensation of being infested with insects associated with delusions of infestation, or the perception that one emits a foul odor from a body orifice associated with delusions of reference). *Apart from the direct impact of the delusions, psychosocial functioning is not markedly impaired, and behavior is neither obviously odd nor bizarre* (Criterion C). If mood episodes occur concurrently with the delusion, the total duration of these mood episodes is relatively brief compared to the total duration of the delusional periods (Criterion D). The delusions are not due to the direct physiological effects of a substance (e.g., cocaine) or a general medical condition (e.g., Alzheimer's disease, systematic lupus erythmatosus) (Criterion E).

(ROA at 638-639) (DSM-IV at 296) (emphasis added). Persons suffering from delusional disorder may be unimpaired in their occupational and social roles, and

any delusions are generally plausible ideas "that can conceivably occur in real life". *Id.* at 297. In fact, prior to and at the time of his arrest, Dr. Sell was functioning perfectly well in society. (ROA at 640).

Delusional disorder may be subcategorized based upon the predominant delusional theme. Dr. Sell has been diagnosed as suffering from the persecutory subtype of delusional disorder, which DSM-IV defines as follows:

> **Persecutory Type.** This subtype applies when the central theme of the delusion involves the person's belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals. Small slights may be exaggerated and become the focus of a delusional system. The focus of the delusion is often on some injustice that must be remedied by legal action ("querulous paranoia"), and the affected person may engage in repeated attempts to obtain satisfaction by appeal to the courts and other government agencies. Individuals with persecutory delusions are often resentful and angry and may resort to violence against those they believe are hurting them.

DSM-IV at 298.

The indicated treatment for delusional disorder is still the subject of debate. (See April 4, 2001 Order) (Judge Stohr acknowledging the debate among experts). For example, one of the texts relied upon by government clinicians and which government clinicians have testified to as being authoritative in the field (ROA at 584) has described the treatment indicated for persons suffering from delusional disorder as follows:

> The goals of treatment are to establish the diagnosis to decide on appropriate interventions, and to manage complications. Fundamental

> to the success of those goals is an effective and therapeutic doctor-patient relationship. Establishing that is far from simple. The patients do not complain about psychiatric symptoms and often enter treatment against their will. Even the psychiatrist may be brought into their delusional nets . . . .
>
> Delusional disorder is a psychotic disorder by definition, and the natural presumption has been that the condition would respond to antipsychotic medication. Because controlled studies are lacking and the disorder is uncommon, the results required to support this practice have not yet been obtained.

Comprehensive Textbook of Psychiatry (4th Ed. C. 15.2, p. 1048.) During the involuntary medication hearing, however, both Government witnesses testified that antipsychotic medication was effective in treating delusional disorder. (*See*, Transcript of September 29, 1999 Involuntary Medication Hearing, ROA at 526 *et seq.*)

IV. The Involuntary Medication Proceedings

In 1999, the Center sought to forcibly drug Dr. Sell to restore him to competency. (*See, e.g.*, ROA at 347-50) (Motion for appointed counsel to attend administrative proceeding). On June 9, 1999, the Center conducted an administrative hearing pursuant to 28 C.F.R. § 549.43 after which the Center authorized itself to forcibly drug Dr. Sell with antipsychotic medication to restore Dr. Sell to competency. In connection with these proceedings, Dr. Glazzard, the Center's reviewing psychologist at the time, prepared an Involuntary Medication Report ("IMR"). (ROA at 967 *et seq*.) In the IMR, Dr. Glazzard summarized Dr.

Sell's statement in opposition to the medication as follows: "I do not want to take medicine. I do not want my chemistry altered. My brain is working well." (ROA at 967).

At the hearing, the Government did not claim that Dr. Sell was dangerous. The IMR contained a specific section setting forth options for the examiner to check off the specific findings upon which the involuntary medication determination had been made. (ROA at 969). The entries include dangerousness and competency to stand trial. (ROA at 969). The dangerousness entry was marked "No." (ROA at 969). The competency to stand trial entry was marked "Yes." (ROA at 969). The Warden reviewed and affirmed the administrative decision. He, too, did not find Dr. Sell to pose a danger to himself or others.

Dr. Sell then sought judicial review of the administrative decision, which the Magistrate Judge granted on August 20, 1999. (ROA at 357, 517-519). The judicial hearing was held on September 29, 1999. (ROA at 523). At the hearing, the Government claimed for the first time (without notice to Dr. Sell) that Dr. Sell should be forcibly drugged because Dr. Sell posed a danger to himself or others. (ROA at 526 *et seq.*). The basis for the Government's dangerousness theory was, among other things, Dr. Sell's alleged acts of familiarity with a nurse (Nurse Goldberg) at the Center—acts such as addressing the nurse by her first name. (ROA at 569-71, 645). The Magistrate Judge heard the testimony of Government

psychologists, who opined that this behavior evidenced dangerousness. (ROA at 526 *et seq.*).

Almost a year later, on August 9, 2000, the United States Magistrate Judge entered an Order finding that Dr. Sell posed a danger to himself and others. (ROA at 805-821). Based upon this finding, the Magistrate Judge authorized the Government to forcibly medicate Dr. Sell with antipsychotic drugs. (*Id*.) Dr. Sell sought review of the Magistrate Judge's Order with the District Court. (ROA at 846-864).

On April 4, 2001, the District Court reversed the Magistrate Judge's finding that Dr. Sell posed a danger to himself or others. (April 4, 2001 Order). The District Court held that the record evidence was insufficient to support such a finding and that the Magistrate Judge's decision was therefore clearly erroneous:

> The record does not indicate that defendant has posed a danger to himself or others during the period of his institutionalization at the [Center], and the statements and conduct relied upon for a finding of dangerousness do not suggest a threat of violence to the staff. Without more, this Court deems it clearly erroneous to conclude that defendant presents a danger to himself or others sufficient to constitute a compelling state interest outweighing his interest in refusing anti-psychotic medication . . . .
>
> The claim of dangerousness may also be a *post hoc* justification . . . . Dangerousness in his prison setting was not a basis for the administrative decision to forcibly medicate defendant . . . .

(April 4, 2001 Order at 11-12) (internal citations and quotations omitted).

Despite finding the Magistrate Judge's decision to be clearly erroneous, the District Court affirmed the Magistrate Judge's Order on a different ground. (April 4,

2001 Order at 16-17). The Court held that the Government's interest in restoring Dr. Sell to competency was alone sufficient to warrant forcible medication:

> This Court agrees with the magistrate judge that this is such a case [warranting involuntary medication for the sole purpose of restoring competency]. The interest in adjudication of the charges is less compelling in cases involving lesser offenses . . . . The seriousness of [the charges against Dr. Sell] contribute[] greatly to the compelling strength of the government's interest in adjudicating defendant's guilt.

(April 4, 2001 Order at 16-17). On this ground, the District Court affirmed the Magistrate Judge's involuntary medication order.

V. Antipsychotic Drugs

Antipsychotic medications are potent, mind-altering drugs with the potential for severe, irreversible, and even deadly side effects. (ROA at 556) (Dr. DeMier acknowledging that the side effects are "significant"). Antipsychotic drugs do not cure mental illnesses; the simply suppress the symptoms. (*See, e.g.*, ROA at 661, 676) (Dr. Wolfson testifying that drugs stop the expansion of delusions do not "resolve" the underlying illness).

The efficacy of antipsychotic drugs in cases of delusional disorder is uncertain. (*See, e.g.*, Transcript of September 29, 1999 Involuntary Medication Hearing at ROA at 526 *et seq.*) (Judge Stohr acknowledging the disagreement among experts); (ROA at 589) (Dr. DeMier testifying that "in many cases" delusional symptoms abate). Sources vary in their assessment of the percentage of patients who actually benefit from the drugs. (*Id.*) In addition, physicians

typically prescribe antipsychotic drugs on a trial and error basis; there is no accurate method of determining how a patient will respond to a particular drug. (*See, e.g.,* ROA at 615) (Dr. Wolfson testifying that he administers drugs on trial and error basis to determine whether a given drug is suited to a patient).

These potential difficulties inherent in Dr. Sell's efforts to resist forced drugging are complicated by the fact that the Government will not disclose the precise drugs it intends to administer. (ROA at 556) (Dr. DeMier testifying that he "would not recommend one agent over another" because he "doesn't have the expertise.") (ROA at 615) (Dr. Wolfson testifying that he prefers "not to get pinned down" to a single drug.). Moreover, the efficacy of the medication varies according to a given case history. (*See, e.g.,* ROA at 534, 590) (antipsychotic medication is less effective when treatment is delayed for a significant period of time).

At the September 29, 1999 involuntary medication hearing (ROA at 526 *et seq.*), the Government called two witnesses: Dr. DeMier, the Center psychologist treating Dr. Sell, and Dr. Wolfson, the Center psychiatrist who consulted for medication purposes. (*Id.*) Dr. DeMier testified that he has treated two patients suffering from delusional disorder with antipsychotic medication. (ROA at 544-45). Of the two, one was restored to clinical competency. (ROA at 546). The successful antipsychotic medication was Haldol, a typical antipsychotic. (ROA at

555). The unsuccessful drug was Olanzapine, an atypical antipsychotic drug. (ROA at 556). Dr. Wolfson testified that he had treated four patients with delusional disorder with antipsychotic medication. (ROA at 617-618). One of these patients was apparently restored to competency, relapsed, then restored a second time. (ROA at 618-19).

Dr. Wolfson also testified that the new generation of atypical antipsychotic drugs, such as Pimozide, had a more benign side effect profile than the older typical antipsychotic drugs, such as Haldol. (ROA at 614). The Magistrate Judge and District Court relied upon this testimony in finding involuntary medication to be appropriate in Dr. Sell's case. However, Dr. Wolfson also testified that atypical antipsychotic drugs can only be administered orally, and therefore cannot be used to forcibly drug uncooperative patients such as Dr. Sell. (ROA at 614).

In addition, Dr. Sell presented evidence that directly contradicted the Government's testimony regarding the efficacy of antipsychotic medication. Dr. Cloninger testified by affidavit that in his personal experience, as well as the literature he deemed authoritative, antipsychotic medication is not effective for the treatment of delusional disorder. (ROA at 413-416). Because delusional disorder is rare, few psychiatrists have experience in treating it. (ROA at 413, ¶ 4). However, based upon his personal experience and a review of the literature, Dr. Cloninger concluded that "there is no evidence that neuroleptics [i.e., antipsychotic

medication] are beneficial for patients with delusional disorder." (ROA at 414, ¶ 8). Further, Dr. Cloninger submitted a report by Opjordsmoen and Rettorstol that reached the same conclusion. (ROA at 414, p 6; 473-477). He also submitted an authoritative text that indicates antipsychotic medication may be useful for anxiety, agitation, and psychosis, but will not alone be effective in eliminating delusional disorder. (ROA at 414, ¶9; 465). Dr. Sell also presented the court with a report from the Federal Bureau of Prisons Institutional Metropolitan Correctional Center ("MCC Chicago"), in which Dr. Daniel Greenstein, the forensic psychologist MCC Chicago, stated that "[d]elusional disorder does not typically respond to pharmacological intervention or psychotherapy." (ROA at 587). In its Order, the District Court specifically acknowledged the conflicting views among the experts. (April 4, 2001 Order at 7) ("[T]here exist differences of opinion among practitioners in the field, including the experts relied upon by the parties . . . ."). The District Court ordered that Dr. Sell be forcibly medicated.

VI. Dr. Sell's Confinement at the Center

The District Court's original April 14, 1999 Order authorized the Government to confine Dr. Sell for four months. (ROA at 341-42). This four month period expired on August 14, 1999. On August 29, 1999, the District Court entered an order authorizing the Government to continue Dr. Sell's confinement for an additional reasonable period of time—120

days. (ROA at 328-29). This 120 day extension expired on December 27, 1999. Despite the expiration of the court's orders, the Government continued to confine Dr. Sell. When Dr. Sell moved for relief from this detention, the Court ordered Dr. Sell confined for an additional 120 days, and to date has continued to order subsequent 120-day periods of confinement with occasional lapses during which time Dr. Sell has been confined in the Center without an order authorizing his detention. (*See, e.g.*, ROA at 730-746; 1001-09).

Dr. Sell's efforts to resist involuntary medication have been further complicated by the nature of his confinement at the Center. For example, Dr. Sell has spent a significant amount of time isolated in Section 10E, the Center's lockdown unit. In the lockdown unit, detainees are isolated for twenty-three hours a day behind steel doors, notwithstanding that isolation is contraindicated for persons afflicted with delusional disorder. (ROA at 551). In addition, Dr. Sell has not received any psychological treatment for his delusional disorder during his confinement in the Center. (ROA at 547, 559).

Dr. Sell has also been subjected to physical abuse. For example, Dr. Sell has complained to the District Court that on or about November 9, 1999, between six and twelve guards equipped in riot gear forcibly removed Dr.

Sell from his cell, dragged him down the stairs by chains wrapped behind his back, shackled his hands and legs to a heavy object inmates refer to as the "black box," and injected him with a drug that left him unconscious for perhaps as long as a day. (ROA at 740). Although the incident was videotaped, the Bureau of Prisons has denied Dr. Sell's repeated direct requests for the videotapes and his repeated Freedom of Information Act requests. On another occasion, Dr. Sell has complained that a Center guard attached a hose to a hot water spigot and sprayed Dr. Sell with scalding water while Dr. Sell was locked in the narrow confines of the cage in which he was forced to shower and hence unable to avoid the spray of water.

SUMMARY OF THE ARGUMENT

The Court should reverse the District Court's April 4, 2001 involuntary medication order for the following reasons:

The Magistrate Judge ordered Dr. Sell to be forcibly medicated with antipsychotic drugs for the sole purpose of restoring Dr. Sell's competency to stand trial. Relying upon *Riggins v. Nevada*, 504 U.S. 127 (1992), the District Court held that the Government's interest in prosecuting a criminal defendant coupled with the nature of the charges against Dr. Sell warranted forcible drugging. However, the Supreme Court did not hold in *Riggins* that the Government's interest in prosecution and the nature of the charges alone are sufficient to overcome a detainee's protected liberty interest in resisting forced medication. Instead, the Court suggested, and Justice Kennedy specifically stated in his concurrence, that the Government must make an extraordinary showing to medicate a detainee for the sole purpose of restoring competency. The District Court erred because the Government made no extraordinary showing that would warrant involuntary medication.

The Government also failed to prove each of the prerequisites to involuntary medication by clear and convincing evidence. In the September 29, 1999 involuntary medication hearing, the Government presented evidence that Dr. Sell was dangerous and should therefore be drugged against his will. The record is

devoid of any meaningful testimony about the specific effects the medication will have on the issue of competency. Instead, the District Court found that Dr. Sell's objections to the administration of antipsychotic drugs were too generalized. The District Court erred by failing to require the Government to prove each of the prerequisites to involuntary medication by clear and convincing evidence and by thereby effectively shifting the burden to Dr. Sell to disprove the Government's involuntary medication case.

The District Court also erred by applying an improper standard of review. The Magistrate Judge's findings were made under the deferential rational relationship standard applicable to the involuntary medication analysis in the context of dangerousness. The District Court found that Dr. Sell is not presently dangerous, and, therefore, the strict scrutiny standard should have been applied to the issue of whether Dr. Sell could be medicated for the sole purpose of restoring him to competency. The District Court erred by conducting a balancing test that is inconsistent with the strict scrutiny standard and by relying upon findings of fact made under a more deferential and inapposite standard.

The District Court erred, finally, in ordering involuntary medication without conducting a premedication analysis of how Dr. Sell's right to a fair trial might be compromised by the forcible injection of antipsychotic medication. Relying upon a recent district court case in the District of Columbia, the District Court held that

Dr. Sell's objections to involuntary medication based upon concerns that the drugs would impair his Sixth Amendment rights to a fair trial were "premature". However, the Sixth Circuit and the District of Columbia Circuit have held that a court must conduct a Sixth Amendment inquiry before the medication is administered. If the only determination of the Sixth Amendment issue is made after the defendant is medicated against his will, the determination comes too late. The District Court therefore erred by failing altogether to take into account the effect forcible medication will have on Dr. Sell's right to a fair trial.

ARGUMENT

I. THE DISTRICT COURT ERRED IN ORDERING DR. SELL'S INVOLUNTARY MEDICATION FOR THE SOLE PURPOSE OF RESTORING HIS COMPETENCY TO STAND TRIAL BECAUSE THE NATURE OF THE CRIMINAL CHARGES ALONE CANNOT SATISFY THE GOVERNMENT'S BURDEN OF MAKING AN EXTRAORDINARY SHOWING.

A. Standard of Review

The issue presented by the case at bar is whether the nature of criminal charges alone is sufficient to satisfy the Government's burden of making an extraordinary showing that would warrant involuntary medication for the sole purpose of restoring a pretrial detainee's competency to stand trial. Because this is an issue of law, this Court's review is *de novo*. *See, e.g., Leech Lake Tribal Council v. Washington Nat. Ins. Co.*, 227 F.3d 1054, 1056 (8th Cir. 2000) (acknowledging questions of law are reviewed *de novo*); *see also United States v. Benning*, -- F.3d --, 2001 WL 428235, No. 00-2674, at * 2 (8th Cir. (S.D. April 27, 2001)) (reviewing proffered defense *de novo* as a question of law).

B. Discussion

The issue of involuntary medication with antipsychotic drugs implicates the most fundamental concepts of privacy and liberty. "No right is more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Woodland v.*

Angus, 820 F. Supp. 1497, 1504 (D. Utah 1993) (quoting *Cruzan v. Missouri Dept. of Health*, 497 U.S. 261, 269, 110 S. Ct. 2841, 2846 (1990)). Forcibly drugging Dr. Sell would not only constitute an intrusion into Dr. Sell's body, but an intrusion into his mind, personality and identity:

> In a society whose 'whole constitutional heritage rebels at the thought of giving government the power to control men's minds,' the governing institutions, and especially the courts, must not only reject direct attempts to exercise forbidden domination over mental processes; they must strictly examine as well oblique intrusions likely to produce, or designed to produce, the same result.

Bee v. Greaves, 744 F.2d 1387, 1394 (10th Cir. 1984) (quoting L. Tribe, *American Constitutional Law* § 15-5, at 899 (1978)) (quoting *Stanley v. Georgia*, 394 U.S. 557, 565, 89 S. Ct. 1243, 1248 (1969)). In this case, the Government does not merely request an "oblique intrusion" into Dr. Sell's mind; it seeks to drug Dr. Sell for the sole and undisputed purpose of altering his cognitive processes in order to prosecute him.

The United States Supreme Court first recognized that prisoners have a due process right to resist forcible medication in *Washington v. Harper*, 494 U.S. 210, 110 S.Ct. 1028 (1990). In *Harper*, a convicted prison inmate claimed that the State of Washington violated his due process rights by administering antipsychotic drugs against his will. The Court held that that "[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty," and that a criminal defendant therefore

possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause. *Washington v. Harper*, 494 U.S. at 221-22, 229. However, the Court held that mentally ill inmates could be treated with antipsychotic drugs where the government has an overriding justification and there is a determination that the inmate was dangerous to himself or others and the treatment was in the inmate's best medical interest. *Id.* at 227.

The Court had occasion to further refine the involuntary medication analysis in *Riggins v. Nevada*, 504 U.S. 127 (1992). In *Riggins*, the defendant was convicted in state court of murder and sentenced to death. A few days after being taken into custody, Riggins had reported to his treating psychiatrist that he had heard voices in his head and had had trouble sleeping. *Id.* at 129. The psychiatrist prescribed an antipsychotic medication that Riggins had been taking prior to his arrest. *Id.* After the court found Riggins competent to stand trial, the defense moved the district court for an order suspending the administration of the medication, arguing that such medication would affect his demeanor and mental state and therefore deny him due process. *Id.* at 130. He also complained that because he intended to offer an insanity defense, he was entitled to show jurors his "true mental state." *Id.*

The District Court denied Riggins' request to suspend medication without explanation. Thereafter, Riggins asserted the insanity defense, testified on his

own behalf at trial, and was convicted. The Supreme Court of Nevada affirmed the conviction, and the Supreme Court of the United States granted *certiorari* to entertain Riggins' constitutional challenge to his involuntary medication.

The *Riggins* Court first acknowledged that under *Harper* "forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness." *Riggins*, 504 U.S. at 135. The Court then held that a pretrial detainee—such as Riggins at the time he requested the suspension of medication—should be afforded "at least" the same protections as a convicted prisoner. *Id.*; *see also Bell v. Wolfish*, 441 U.S. 520, 545, 99 S. Ct. 1861, 1877 (1979) ("*A fortiori*, pretrial detainees, who have not been convicted of any crimes, retain *at least* those constitutional rights that we have held are enjoyed by convicted prisoners.") (emphasis added); *United States v. Weston*, 134 F. Supp. 2d 115, 120, 2001 WL 286406, No. CRIM. A. 98-357 (D.D.C. March 6, 2001) (citing *Riggins*, 504 U.S. at 135) ("A pretrial detainee's liberty interests are at least equal to that of a convicted prisoner.").

The Court identified situations in which the Government might potentially be able show an "overriding justification" sufficient to warrant involuntary medication:

> Although we have not had occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial settings, Nevada certainly would have satisfied due process if the prosecution had demonstrated, and the District Court had found,

> that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others. Similarly, the State might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence by using less intrusive means.

Riggins, 504 U.S. at 135 (internal citations and quotations omitted).

Under this formulation, the threshold inquiry is whether antipsychotic medication is medically appropriate. If a drug is not medically appropriate (considering less intrusive alternatives), then the inquiry ceases, and a court may not order involuntary medication. If medication is medically appropriate, then the government must still satisfy its burden of proving an overriding justification by showing that the defendant is dangerous or by making an even more extraordinary showing of a compelling Government interest in medicating a pretrial detainee for the sole purpose of restoring competency. Thus, if the court were to find that treatment of delusional disorder with antipsychotic medication is not medically appropriate, then forcible medication would not be an option.

In the case at bar, the District Court authorized the Government to forcibly drug Dr. Sell for the sole purpose of restoring Dr. Sell's competency to stand trial. (*See* April 4, 2001 Order). In *Riggins*, the Court acknowledged that the Government "*might* be able to justify . . . involuntary treatment with the drug by establishing that it could not obtain an adjudication of guilt or innocence by using

less intrusive means." *Riggins*, 504 U.S. at 135 (emphasis added). However, contrary to the reasoning implicit in the District Court's opinion, the *Riggins* decision does not authorize involuntary drugging solely because the Government suspects it will otherwise be unable to prosecute a defendant charged with a serous crime. As Justice Kennedy explained in his concurrence:

> I file this separate opinion, however, to express my view that *absent an extraordinary showing by the State*, the Due Process Clause prohibits prosecuting officials from administering involuntary doses of antipsychotic medicines for purposes of rendering the accused competent for trial, and to express my doubt that the showing can be made in most cases, given our present understanding of the properties of these drugs . . . .
>
> Here the purpose of the medication is not merely to treat a person with grave psychiatric disorders and enable that person to function and behave in a way not dangerous to himself or others, but rather to render the person competent to stand trial. It is the last part of the State's objective, medicating the person for the purpose of bringing him to trial, that causes most serious concern. If the only question were whether some bare level of functional competence can be induced, that would be a grave matter in itself, but here there are even more far reaching concerns. The avowed purpose of the medication is not functional competence, but competence to stand trial. In my view elementary protections against state intrusion require the State in every case to make a showing that there is no significant risk that the medication will impair or alter in any material way the defendant's capacity or willingness to react to the testimony at trial or to assist his counsel. Based upon my understanding of the medical literature, I have substantial reservations that the State can make that showing. Indeed, the inquiry itself is elusive, for its assumes some baseline of normality that experts may have some difficulty in establishing for a particular defendant, if they can establish it at all. These uncertainties serve to underscore the difficult terrain the State must traverse when it enters this domain.

Riggins, 504 U.S. at 139, 140-41 (emphasis added).

The only "extraordinary showing" referred to in the District Court's opinion in the case at bar is the nature of the charges against Dr. Sell. The charges pending against a defendant—standing alone—should not be considered a sufficient basis for involuntary medication. Drugging defendants based upon the Government's charges prior to an adjudication of guilt is an affront to the presumption of innocence afforded all criminal defendants. Moreover, in this case, the Government's conspiracy and attempted murder charges are based upon a single taped conversation between a government informant and Dr. Sell containing cryptic comments from which the Government has manufactured a sinister murder plot—comments provoked by government agents who were all too aware of Dr. Sell's vulnerability to suggestions advocating anti-government positions.

Even if the Government's allegations had merit (which cannot be assumed), such conduct could hardly satisfy the Government's burden of making an extraordinary showing that could trump a pretrial detainee's liberty interest in being free from bodily intrusion. The Government has diagnosed Dr. Sell as suffering from delusional disorder. This disorder manifests itself in particular with regard to his perceived persecution by the United States Government. Persons suffering from delusional disorder often make defensive comments or engage in defensive activity to protect themselves from the perceived threat. Dr. Sell

perceives Government agents to be the threat. The fact that the Government has recorded Dr. Sell making comments the Government interprets as threats against Government agents is simply symptomatic of the mental illness with which the Government has diagnosed him; it is not extraordinary. (*See, e.g.*, ROA at 537) (Dr. Sell refers to the federal government as the "Anti-Christ"), 548 (Dr. Sell has a particular mistrust of the federal government), and 544 (person suffering from delusional disorder would naturally react by defending himself from perceived threat).

In addition, the Supreme Court has implicitly rejected the argument that the charges alone can justify forced medication. The Defendant in *Riggins*--the very case in which Justice Kennedy admonished that some additional "extraordinary showing" was necessary--was *convicted* of murder and sentenced to death. Neither Justice Kennedy nor the Court suggested that the nature of the charges alone could satisfy the "extraordinary showing" requirement. Yet, in the instant case, contrary to Justice Kennedy's admonitions, the District Court has essentially held that any defendant suffering from a psychosis (such as delusional disorder) who is charged with a serious crime is categorically subject to forcible drugging, irrespective of the idiosyncrasies of a given defendant or the particulars of a given case.

Dr. Sell has now been confined for over three years without a trial—two of which have been spent in the Center, where he was supposed to have received

treatment. He has *at least* as great an interest in obtaining an adjudication of his guilt or innocence as does the Government. Yet, despite the fact that the Government apparently has the power to confine Dr. Sell indefinitely without a trial, Dr. Sell steadfastly maintains that the potential side effects of antipsychotic medication on his mind and body outweigh his interest in proceeding to trial. Moreover, the Government is not without recourse if this Court determines that the restoration of competency alone is an insufficient basis for forced governmental drugging. *See Riggins*, 504 U.S. at 145 ("if the State cannot render the defendant competent without involuntary medication, then it must resort to civil commitment . . . .") (Kennedy, concurring). Thus, while courts have not had an opportunity to elaborate on the substantive standards applicable to determine whether the Government has made the extraordinary showing required to involuntarily medicate an unconvicted detainee to restore competency, it is clear that the nature of the charges alone should be deemed insufficient.

As the foregoing demonstrates, the Government has not made an extraordinary showing that would warrant the forcible drugging of Dr. Sell for the sole purpose of restoring his competency to stand trial. Therefore, the Court should reverse the District Court's April 4, 2001 Order.

II. THE DISTRICT COURT ERRED IN ORDERING THE FORCIBLE MEDICATION OF DR. SELL BECAUSE THE GOVERNMENT FAILED TO PROVE THE PREREQUISITES TO INVOLUNTARY MEDICATION BY CLEAR AND CONVINCING EVIDENCE.

A. Standard of Review

The issues presented to the Court are whether the District Court applied the correct standard of review and whether the Government carried its burden of establishing each of the prerequisites to involuntary medication by clear and convincing evidence. In determining whether the District Court applied the proper burden of proof, this Court's standard of review is *de novo*. *See Trull v. Volkswagen of America, Inc.*, 187 F.3d 88, 93 (1st Cir. 1999) ("[T]he legal determination of the appropriate burden of proof . . . is a question of law entitled to *de novo* scrutiny."). In reviewing the District Court's specific findings of fact, such as medical appropriateness or the probability of restoring competency (to the extent any such finding was actually made), this Court's standard of review is the clearly erroneous standard. *Love v. M.D. Reed*, 216 F.3d 682, 687 (8th Cir. 2000). To the extent a review of the District Court's involuntary medication analysis involves a review of mixed questions of law and fact, the *de novo* standard applies. *Boysiewick v. Schriro*, 179 F.3d 616, 619 (8th Cir. 1999).

B. Discussion

As shown above, *Riggins* establishes that in order to forcibly medicate a defendant, the Government must, at a minimum, show that: (1) the medication is

medically appropriate, considering less intrusive methods; and either (2) the defendant poses a danger to himself or others, or (3) that the medication has a reasonable probability of restoring a defendant's competency. The Court left open for later adjudication the standard of proof required on these issues.

In fact, only one United States Court of Appeals decision appears to have addressed the precise issue before this Court: the burden of proof applicable in involuntary medication proceedings initiated solely for the purpose of restoring a pretrial detainee to competency to stand trial. In *United States v. Brandon*, 158 F.3d 947 (6th Cir. 1998), a pretrial detainee sought a judicial hearing to determine whether he could be involuntarily medicated to render him competent to stand trial. Personnel at the institution in which he was detained sent a report to the district court recommending involuntary medication with antipsychotic medication, subject to the protections of the required administrative proceedings under 28 C.F.R. § 549.43. Brandon moved for an evidentiary hearing, which the district court denied. The District Court applied a deferential standard of review (rational-basis review) and held that the administrative proceedings would be sufficient to protect Brandon's due process rights. *Id.* at 950. Brandon immediately appealed.

The Sixth Circuit acknowledged that the prospect of involuntary medication implicated Brandon's First Amendment interest in protecting his ability to communicate ideas, his Fifth Amendment liberty interest in being free from bodily

intrusion, and his Sixth Amendment right to a fair trial. *Brandon*, 158 F.3d at 954. The court also recognized the Government's significant interest in prosecuting criminal cases. *Id.* at 954.

The Sixth Circuit proceeded to prescribe the burden of proof[1] applicable to an involuntary medication proceeding to restore competency:

> We believe that the risk of error and possible harm involved in deciding whether to forcibly mediate an incompetent, non-dangerous pretrial detainee are likewise so substantial as to require the government to prove its case by clear and convincing evidence.

Brandon, 158 F.3d at 961. Thus, the Sixth Circuit held that the Government bears the burden of proving each of the involuntary medication issues by clear and convincing evidence. *See also United States v. Weston*, 134 F. Supp. 2d 115, 121, 2001 WL 286406, No. CRIM. A. 98-357 (D.D.C. March 6, 2001) (citing *Riggins*, 504 U.S. at 135). Defendants deemed incompetent to stand trial are not required to disprove the Government's conclusory allegations of dangerousness or medical appropriateness; the Government is required to prove each and every prerequisite to involuntary medication by clear and convincing evidence, which courts have defined as evidence that would "place in the ultimate factfinder an abiding conviction that the truth of its factual contentions are 'highly probable'" such that the evidence it offers "instantly tilted the evidentiary scales in the affirmative when

[1] The *Brandon* court's analysis of the proper standard of review is set forth, *infra*, in Argument III.

weighed against the evidence" in opposition. *Colorado v. New Mexico*, 467 U.S. 310, 316, 104 S.Ct. 247 (1984).

In the case at bar, the District Court impermissibly relieved the Government of this burden. For example, the court dismissed Dr. Sell's concerns regarding the side effects of antipsychotic medication based, in part, upon a finding that the Government could administer the new generation of atypical antipsychotic medication, which has a more benign side effect profile. However, the Government's own testimony demonstrates that atypical medications can only be administered orally and are therefore not suited to involuntarily medicate uncooperative patients such as Dr. Sell.

Likewise, the Government did not prove by clear and convincing evidence that the administration of antipsychotic medication had a reasonable probability of restoring Dr. Sell's competency to stand trial. Instead, the Magistrate Judge found (and the District Court upheld the finding) that antipsychotic medication was the only way to restore Defendant's competency, if it were possible at all. However, a finding that medication is the sole means of restoring a defendant's competency to stand trial is alone insufficient to warrant forced medication. "[T]here must be at least a showing that such a course of action can *reasonably be expected to in fact render the [nonconsenting individual] competent.*" *Woodland v. Angus*, 820 F. Supp. at 1512 (1993) (emphasis added).

As discussed, *infra*, the proper inquiry is two pronged: first, the medical professionals testify as to how the medication will affect a detainee; second, the court applies those findings and conducts its own legal analysis as to whether those effects would create a substantial probability that competency would in fact be achieved. Neither the Magistrate Judge nor the District Court has analyzed the probability that Dr. Sell would be restored to legal competency. Instead, the District Court erroneously relied upon the opinions of Government clinicians. Such reliance to determine the issue of *legal* competency is inappropriate. *See United States v. Brandon*, 158 F.3d at 955 ("Physicians are not equipped to determine the effect that the drugs will have on Brandon's right to a fair trial and right to counsel. Rather, the district court must understand and apply the medical recommendations of the physicians in making such decisions."). In this case, the District Court simply relied upon the Magistrate Judge's deferential adoption of the Government's anecdotal evidence and failed to apply the required legal analysis to that evidence. As a result, the District Court improperly shifted the burden to Dr. Sell to prove that the drugs (the identities of which are secret) would be ineffective.

Not only are the District Court's general findings concerning the efficacy of antipsychotic drugs and their side effects flawed, the District Court also erred in relying upon the Magistrate Judge's specific findings of fact. For example, the Magistrate Judge in part based its initial decision to forcibly drug Dr. Sell on a

finding that tardive dyskinesia (arguably the greatest risk associated with antipsychotic drugs) is "not permanent." (August 9, 2000 Order at 8). This assertion is incorrect. The disorder is irreversible. Indeed, the Government's own testimony indicated that tardive dyskinesia is a permanent condition. (ROA at 556-57). Moreover, symptoms of tardive dyskinesia can develop in elderly patients such as Dr. Sell three to five times faster than in younger patients. Although the Magistrate Judge subsequently stated that these mistakes would not have altered his order, they are indicative of the inaccuracies that pervade the Government's testimony regarding antipsychotic medication.

Similarly, the District Court's finding that neuroleptic malignant carcinoma (which produces fever, skeletal rigidity, elevated blood pressure, delirium, mutism, stupor, coma and death) occurs in only 1 in 10,000 patients are unfounded. In fact, neuroleptic malignant carcinoma affects approximately two percent of patients who use neuroleptic medication. William M. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937, 950 (1998).

Likewise, contrary to the Magistrate Judge's findings, drug-induced parkinsonism develops in about 40% of older adults treated with typical antipsychotic drugs, even when given low doses. *Side Effects of Antipsychotic Drugs: Avoiding and Minimizing Their Impact in Elderly Patients*, POSTGRADUATE

MEDICINE (2000). Indeed, in the elderly, "irreversible side effects may occur after only a few weeks of antipsychotic treatment." *Id.*

Although Drs. DeMier and Wolfson would not identify the specific drugs the Government intends to administer, the drugs they did mention, such as Olanzapine and Pimozide, have been the subject of criticism. *See, e.g.*, Michael T. Compton, Aida Saldivia, Sally A. Barry, *Recurrent Priapism During Treatment with Clozapine and Olanzapine,* AMERICAN JOURNAL OF PSYCHIATRY (2000); *see also Mealey's Emerging Drugs and Devices, Deaths Reported Among Users of Tourette's Drug,* 4 No. 19 (1999) (noting occurrence of at least two sudden deaths based on administering Pimozide in conjunction with certain at other drugs); *Chemicals Added to Prop. 65 List*, 7 CAL. ENVTL. INSIDER 4 (1999) (the State of California adding Pimozide to its list of drugs "known to the state" to cause either cancer or reproductive toxicity). Indeed, the Magistrate Judge's and District Court's suggestions that the new generation of atypical antipsychotic drugs are universally safe and effective for the treatment of any mental illness causing delusions is unfounded. Some of the most recent generation of atypical psychotropic drugs appear safe because they have not been available long enough to allow meaningful study into the instances and extent of side effects. *See, e.g.*, *Side Effects of Antipsychotic Drugs: Avoiding and Minimizing Their Impact in Elderly Patients*, POSTGRADUATE MEDICINE (2000) (Clozapine causes

agranulocytosis (which can be deadly), increased heart rate, and a lower seizure threshold, thereby restricting its use as a first-line therapy.) These side effects associated with the most recent generation of antipsychotic drugs are particularly troublesome because no studies exist proving their therapeutic efficacy. *See, e.g.* Thomas G. Gutheil & Paul S. Appelbaum, *"Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 HOFSTRA L. REV. 77, 101 (1983); Dennis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283, 296 (1992); Dilip V. Jeste et al., *The Biology and Experimental Treatment of Tardive Dyskinesia and Other Related Movement Disorders*, 8 AMERICAN HANDBOOK OF PSYCHIATRY 536, 560 (Berger & Brodie eds., 2d ed. 1986).

Reference guides have catalogued the various side effects of antipsychotic drugs as follows:

- low blood pressure, dizziness, dry mouth, skin itching, urinary retention, fainting, constipation, and depression;
- acute dyskinesia, consisting of involuntary movements of the muscle system (such as inability to keep legs still) or paralysis (causing the eyeballs to roll up in the head);
- agranulocytosis, a condition which damages the blood-producing system and can result in death;
- akathisia, characterized by involuntary motor restlessness, constant pacing, and an inability to sit still, often accompanied

by fidgeting, chewing, lip movements, and finger and leg movements;

- akinesia, resulting in lack of spontaneity, lifelessness, an inability to participate in usual social activities, and a disinclination to speak;
- blue people syndrome, a condition caused by the deposition of blue pigment in the skin resulting from the administration of Thorazine;
- dystonia, a spasmodic muscle reaction frequently involving a twisting of the neck;
- neuroleptic malignant syndrome, a relatively rare condition which can lead to death from cardiac dysfunction;
- pseudo-Parkinsonian syndrome, causing a mask-like face and rigid hands;
- tardive dyskinesia, a disease caused by long-term use of major tranquilizers, with symptoms including grimacing, chewing, tongue moving, blinking, and abnormal movements of the limbs;
- sudden unexplained death, probably caused by irregular heart beat.

53 Am. Jur. 2d MENTALLY IMPAIRED PERSONS § 113 (1996) (citing cases); (*see also* ROA at 556-558, 610).

The District Court effectively shifted the burden to Dr. Sell to disprove the Government's case. For example, the District Court characterized Dr. Sell's objections to the involuntary administration of drugs as "generalized arguments concerning the efficacy of anti-psychotic drugs." April 4, 2001 Order at 7. Yet, the government will not even disclose the specific drug it intends to inject into him.

How can the Government satisfy its burden of proving each of the required elements by clear and convincing evidence if it has not even decided which drug it will administer? Similarly, how can Dr. Sell make specific arguments as to whether a drug is medically appropriate if the Government refuses to disclose which drug will be administered? Likewise, how can Dr. Sell determine the likelihood that antipsychotic drugs will restore him to competency when the Government keeps the identity of the drug it intends to inject into him a secret?

Therefore, the Government has failed to carry its burden of proving each issue required for involuntary medication by clear and convincing evidence, and this Court should accordingly reverse the District Court's April 4, 2001 Order.

III. THE DISTRICT COURT ERRED IN ORDERING THE FORCIBLE MEDICATION OF DR. SELL BECAUSE THE DISTRICT COURT APPLIED AN ERRONEOUS STANDARD OF REVIEW

A. Standard of Review

The issue presented is whether the District Court improperly adopted the Magistrate Judge's findings of fact and conducted a balancing test without regard to the heightened strict scrutiny standard applicable once the District Court reversed the Magistrate Judge's finding of dangerousness. Because this is a question of law, this Court's review is *de novo*. *Love v. M.D. Reed*, 216 F.3d at 687.

B. Discussion

The Magistrate Judge authorized the Government to forcibly drug Dr. Sell based upon a finding of dangerousness. Acting in an appellate capacity (*see* ROA at n.3 "The Court here act[s] as an appellate court of sorts . . . ."), the District Court ruled that this finding was clearly erroneous, but nevertheless decided to affirm the Magistrate Judge's order on a different ground—namely, that the record supported involuntary medication for the sole purpose of restoring Dr. Sell's competency to stand trial.

In affirming on this alternative ground, the District Court relied upon the Magistrate Judge's findings of fact. The District Court also conducting a balancing test to assess the propriety of forcibly drugging Dr. Sell. The District Court failed, however, to take into account the fact that when it reversed the dangerousness finding, it also changed the standard to be applied to the Government's evidence. The Magistrate Judge made findings of fact and legal conclusions on the medication issue in the deferential context of a dangerousness analysis. *See, e.g.*, *United States v. Morgan*, 193 F.3d 252 (4th Cir. 1999) (holding that a decision to medicate a dangerous inmate in the context of dangerousness as opposed to competency will not be disturbed so long as the decision to medicate was the exercise of the "professional judgment" of a medical professional); *see also Youngberg v. Romeo*, 457 U.S. 307, 324-25, 102 S. Ct. 2452 (1982) (holding that

courts should defer to the judgment of qualified medical professionals). The District Court showed similar deference in affirming the order on different grounds. As the following demonstrates, however, this deference does not apply when medication is sought solely to render a detainee competent to stand trial.

In *United States v. Brandon*, *supra*, 158 F.3d at 955, the court conducted the following analysis in formulating the appropriate standard of review in involuntary medication proceedings seeking to render a defendant competent to stand trial:

> Deciding the appropriate standard of review is crucial, because the ultimate decision in a case is often shaped by the standard applied . . . .
>
> The proposed treatment in the present case affects a non-dangerous pretrial detainee's fundamental right to be free from bodily intrusion. Therefore, the government's request to forcibly medicate Brandon must be reviewed under the strict-scrutiny standard. . . .
>
> In contrast [to *Harper*], the decision in the present case is whether to medicate a non-dangerous pretrial detainee in order to render him competent to stand trial, rather than to protect his safety or the safety of those around him while he is confined. The decision to be made here thus relates solely to *trial* administration rather than to *prison* administration. To forcibly medicate Brandon, therefore, the government must satisfy strict-scrutiny review and demonstrate that its proposed approach is narrowly tailored to a compelling interest.

158 F.3d at 956-57 (internal quotations and citations omitted) (emphasis in original). In so holding, the Sixth Circuit expressly rejected a balancing test. *Id*. at 958 (citing Ashutosh Bhagwat, *Hard Cases and the (D)evolution of Constitutional Doctrine*, 30 Conn. L. Rev. 961, 962 (1998) (discussing the effects of transforming strict scrutiny into an *ad hoc* balancing determination, particularly noting that such

an approach, "produces a tendency . . . to undermine [] the core of the individual liberties protected by the constitution.")).

In order to determine if the Government's interest is "compelling" under the strict scrutiny standard, the court must consider (1) whether the pretrial detainee is dangerous to himself or others, (2) the seriousness of the crime, and (3) whether the detainee will be released from confinement if not made to stand trial. *Brandon*, 158 F.3d at 960 (citing *Riggins*, 504 U.S. at 135). Whether the proposed treatment is narrowly tailored to this interest will turn on whether it is the least restrictive and least harmful means of satisfying the government's goal—rendering the defendant competent to stand trial in a proceeding that is fair to both parties. *Brandon*, 1528 F.3d at 960. The Sixth Circuit then explained the procedural process as follows:

> In the first step of the analysis, the court will receive medical testimony regarding Brandon's mental illness and its symptoms, as well as the effects that antipsychotic medication will have, both beneficial and harmful, and Brandon's physical and mental health. This step involves an analysis of Brandon's condition and treatment that is essentially *medical.*
>
> In the second part of the analysis, the district court will then have to make the *legal* determination of whether Brandon, if forcibly medicated, would be competent to participate in a trial that is fair to both parties. This will require consideration of whether the medication will have a prejudicial effect on Brandon's physical appearance at trial, as well as whether it will interfere with his ability to aid in the preparation of his own defense. In particular, the district court needs to consider the risk that forced medication poses to a pretrial detainee such as Brandon because a drug that negatively affects his demeanor in court or ability to participate in his own defense will not satisfy the government's goal of a fair trial.

> This legal determination is distinct from the medical determination that the medical experts will discuss in step one of the analysis. Antipsychotic medication might sedate Brandon, making him *appear* to be lucid and rationale, for example, but might not make him *in fact* lucid and rational. It is important, therefore, that the medical experts testify about the chemical and behavioral effects of the proposed medication, leaving to the district court the ultimate conclusion of whether those effects will render Brandon legally competent, i.e., whether Brandon would be able to receive a fair trial if forcibly medicated.

158 F.3d at 960 (internal citations omitted) (emphasis in original).

Therefore, once the District Court reversed the finding of dangerousness and opted instead to consider whether the Government could drug Dr. Sell for the sole purpose of restoring competency, the strict scrutiny standard should have been applied. Had the Magistrate Judge applied this standard, it is unclear that he would have found medication to be appropriate. Consequently, the court erred by failing to remand the case to the Magistrate Judge for further findings under the appropriate standard. *See, e.g., Pullman-Standard Div. v. Swint*, 456 U.S. 273, 291, 102 S. Ct. 1781 (1982) ("When an appellate court discerns that a district court has failed to make a finding because of an erroneous view of the law, the usual rule is that there should be a remand for further proceedings to permit the trial court to make the missing findings . . . . Likewise, where findings are infirm because of an erroneous view of the law, a remand is the proper course unless the record permits only one resolution of the factual issue."); *Berger v. Iron Workers Reinforced Rodmen*, 170 F.3d 1111, 1126 (D.C. Cir. 1999) (holding that the district court's

"adoption of an incorrect standard" in making a finding of fact "requires remand of the Special Master's findings"); *Glen Coal Co. v. Seals*, 147 F.3d 502 (6th Cir. 1998) ("To affirm the ALJ's decision, despite the different legal standard applied below would require impermissible appellate fact finding. Therefore, the appropriate remedy here is a remand to the ALJ for review under the appropriate standard . . . .").

In addition, because the Magistrate Judge based his decision upon a finding of dangerousness, the record does not contain all of the findings necessary to order medication on an alternate ground. As a review of the transcript of the September 29, 1999 involuntary medication hearing amply demonstrates, competency was only raised in passing; the hearing focused on dangerousness. The record is insufficient to support involuntary medication for the sole purpose of restoring competency under a strict scrutiny standard.

Finally, the District Court erred by conducting a generalized balancing test rather than the strict scrutiny standard prescribed by *Brandon*. The Magistrate Judge and the District Court repeatedly refer to the balancing of Dr. Sell's medical interests with the state's interest in obtaining a fair adjudication. Under *Brandon*, this type of balancing is inappropriate.

As the foregoing demonstrates, the District Court should have remanded the case to the Magistrate Judge to make findings of fact under the strict scrutiny

standard as to whether antipsychotic medication had a reasonable probability of restoring Dr. Sell's competency and whether the drugs are medically appropriate. As a result, the Court should accordingly reverse the District Court's April 4, 2001 Order.

IV. THE DISTRICT COURT ERRED BY FAILING TO TAKE INTO ACCOUNT WHETHER FORCIBLE MEDICATION WOULD DEPRIVE DR. SELL OF HIS RIGHT TO A FAIR TRIAL.

A. Standard of Review

The final issue presented is whether the District Court erred by failing to undertake a premedication Sixth Amendment analysis. Because this issue is a question of law, this Court's review is *de novo*. *See, e.g., Love v. M.D. Reed*, 216 F.3d at 687.

B. Discussion

In the District Court, Dr. Sell argued that involuntary medication was inappropriate in this case because Dr. Sell intends to interpose a diminished capacity defense to the specific intent crimes with which he is charged. As a result, the issue of forced medication presents Dr. Sell with a legal dilemma. If the medication is effective, it might enhance his ability to communicate with counsel and thereby enable him to assist counsel more effectively in the presentation of his defense. Yet, at the same time, if his cognitive abilities were to improve, his demeanor may likewise appear more coherent and thereby impair his effectiveness

in persuading a jury that he suffered from diminished capacity at the time he is alleged to have committed the crimes with which he is charged. As a result, Dr. Sell's Sixth Amendment right to a fair trial would be compromised.

The District Court concluded that this argument—that forcible medication would impair Dr. Sell's fair trial rights—was "premature" and that any concerns about a fair trial could be addressed in later proceedings. (April 4, 2001 Order at 14). In support of this position, the court relied upon *United States v. Weston*, 134 F. Supp. 2d 115, 2001 WL 286406, No. CRIM. A. 98-357 (D.D.C. March 6, 2001), in which the district court for the District of Columbia adopted a similar approach. However, both the District Court in this case and the district court in *Weston* ignored the holding of the District of Columbia Circuit in that case. The appellate court held that Weston's Sixth Amendment concerns were not only ripe, but that a premedication Sixth Amendment inquiry is an absolute prerequisite to involuntary medication:

> [P]ostmedication review may come too late to prevent impairment of his Sixth Amendment right. Accordingly, both the defendant, whose right to present a defense may be infringed by involuntary medication, and the government, whose eventual prosecution of the defendant may be foreclosed because of the infringement, are *entitled to pre-medication resolution of the Sixth Amendment issue.*

United States v. Weston, 206 F.3d 9, 14 (D.C. Cir. 2000) (emphasis added); *see also Riggins*, 504 U.S. at 139 (Kennedy, J., concurring) ("When the State

commands medication during the pretrial and trial phases of the case for the avowed purpose of changing the defendant's behavior, the concerns are much the same as if it were alleged that the prosecution had manipulated material evidence.").

This requirement of a premedication Sixth Amendment analysis also finds support in the language of the Sixth Circuit's *Brandon* opinion:

> The decision to be made here is whether the detainee may be forcibly medicated so as to render him competent to stand trial . . . . This decision will require the court to consider whether the medication will have a prejudicial effect on Brandon's physical appearance at trial, as well as whether it will interfere with his ability to aid in the preparation of his own defense.

158 F.3d at 955.

Therefore, the District Court erred by failing to analyze the effect medication would have on Dr. Sell's ability to receive a fair trial, and the April 4, 2001 Order should accordingly be reversed.

CONCLUSION

For all the foregoing reasons, the Dr. Sell respectfully requests that the Court reverse the District Court's April 4, 2001 Order and hold that involuntary medication is inappropriate based upon the record. In the alternative, Dr. Sell requests that the Court reverse the District Court's April 4, 2001 Order and remand the case for additional proceedings applying the appropriate legal test for involuntary medication, the appropriate burden of proof, and the appropriate standard of review.

Respectfully submitted,
LEWIS, RICE & FINGERSH, L.C.

Barry A. Short (Counsel of Record)
500 North Broadway, Suite 2000
St. Louis, Missouri 63102
Telephone (314) 444-7600
Facsimile (314) 241-6056

and

FEDERAL PUBLIC DEFENDER

Norman S. London
Lee T. Lawless
Suite 200
1010 Market Street
St. Louis, Missouri 63101
Telephone (314) 241-1255
Facsimile (314) 421-3177

Counsel for Appellant

CERTIFICATE OF COMPLIANCE

COMES NOW counsel for Appellant Dr. Charles Thomas Sell, D.D.S and certifies the following:

1. The Brief of Appellant Dr. Sell complies with the type-volume limitation set forth within Fed.R.App.P. 32(a)(7)(B)(i), in that the Brief contains 11650 words.

2. The word processing software used to prepare the Brief of Appellant was Microsoft Word, Version 8.0, Office 2000.

3. The attached 3 ½ computer diskette contains the Brief of Appellant Dr. Sell. This disk has been scanned by Cheyenne AntiVirus for Windows 95, Version 4. 0 and was found to be free of any virus. In addition, a 3 ½ computer diskette containing the Brief of Appellant Dr. Sell has been served on all counsel of record. See 8th Cir. R. 28A(d).

Barry A. Short
Counsel for Appellant

CERTIFICATE OF SERVICE

The undersigned hereby certifies that two true and accurate copies of the foregoing and a 3.5 inch floppy disk containing a copy of the same were served via hand delivery this ___ day of May, 2001 to:

Dorothy L. McMurtry, Esq.
Howard J. Marcus, Esq.
Assistant United States Attorney
111 South 10th St.
St. Louis, Missouri 63101
Telephone (314) 539-2200
Facsimile (314) 539-2309

Counsel for Respondent